DEPAR	MENT OF HEALTH	AND HUMAN SERVICES	uz +k	(): 12/04/2012 // APPROVED	
		& MEDICAID SERVICES	454>	-01/14113), 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S	SURVEY	
	· · · · · · · · · · · · · · · · · · ·	445408	B. WING		11/3	30/2012	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , ,	7]
SODDY-	DAISY HEALTH CAR	CENTER		01 SEQUOYAH ROAD ODDY-DAISY, TN 37379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TÉMENT OF DÉFICIENCIES / MUST 6E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	F 000				
F 241	completed on Nove 2012.	ification Survey was mber 26 to November 29, AND RESPECT OF	E 244	This Plan of Correction is submitted as required under sand Federal law. The facility			
	The facility must promanner and in an elenhances each res	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.	F 241	submission of the Plan of Correction does not constitute admission on the part of the facility that the findings cited accurate, that the findings constitute a deficiency, or that scope and severity determinates.	are the tion is		
	by: Based on observat failed to maintain th	NT is not met as evidenced ions and interviews the facility e diginity of twenty-two ight residents observed in two		correct. Because the facility r no such admissions, the states made in the Plan of Correctio cannot be used against the fac- in any subsequent administrat or civil proceeding.	ments n cility		
!	The findings include	ed:				,	
!	November 26, 2012	main dining room, on tat 12:05 p.m., revealed staff				\	L
	applying cloth bibs/i residents without as applying the bib.	Clothing protectors to twenty sking the residents before					**
	#1, on November 2	ied Nursing Assistant (CNA) 6, 2012, at 12:05 p.m. ents were not asked prior to					
	November 26, 2012 residents were not a	restorative dining room, on 2, at 11:57 a.m., revealed two asked before having cloth tors applied by staff.				12-28-12	
ABORATORY	DIRECTOR'S OF PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE	1
				NHA	12-	13-12	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient-protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M(JATIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
_		445408	B. WIN	G	441	30/2012
	ROVIDER OR SUPPLIER DAISY HEALTH CAR		,	STREET ADDRESS, CITY, STAYE, ZIP COE 701 SEQUOYAH ROAD SODDY-DAISY, TN 37379		50/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULDBE	COMPLETION OATS
		DER/SUPPLIER REPRESENTATIVE'S SIG		1. No resident was idea 2. Resident Interviews completed on 100% of also oriented residents that attain Dining Areas for conceuse of clothing protectors negative findings reported November 30, 2012 by the Director of Nursing, Assis Director of Nursing, Medi Records Director, Unit Massurance Director. 3. All licensed nurses a Certified Nursing Assistant educated by the Director of Nursing, Unit Manager, Supervisor, and / or Qualit Assurance Nurse on dignit resident choice regarding to of clothing protectors prior time initiated on November 2012 and completed on No 30, 2012.	were art and and meals rns with with no on artant cal anager, ry and ats were af ar of are of	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					0: 12/04/201: 4 APPROVED 0: 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	445408	B. WI	4G	11/	30/2012
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	<u> </u>
SODDY-DAISY HEALTH CARE	CENTER		701 SEQUOYAH ROAD SODDY-DAISY, TN 37379		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
			4. Audit of each Dining will be conducted every me one week, then one meal tin daily three times weekly for weeks, then random meal tin weekly for 2 months and / o 100% compliant by the Unit Manager, Supervisor, Direct Nursing, Assistant Director Nursing, Quality Assurance Director, Medical Records Coordinator, and / or the Mic Coordinator. All findings we reviewed and reported in the Quality Assurance Performation Improvement Committee met for three months and / or un 100% compliance is achieved The Quality Assurance Performance Improvement Committee met Performance Improvement	eal for three nes r until cor of of Sill be ence exting til ed.	
	1 Marie - 100 Mari		Administrator, Medical Dire		
			Director of Nursing, Staff Development Coordinator, Environmental Services, Die Social Services Director, Bu Office Manager, MDS Coordinator, Rehabilitation Department, Medical Record Environmental Department	etary, siness	
BORATORY DIRECTOR'S OR PROVID	058/6/100) (59 BEDDESEXTATIVES SA	CNIATURE	TITLE) (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued orogram participation.

CENT	KINENI OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 12/04/2012
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				M APPROVED 0. 0938-0391
AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE	
		445 4 08	B. WING			
NAME OF	PROVIDER OR SUPPLIER					30/2012
	-DAISY HEALTH CARE	CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODS 701 SEQUOYAH ROAD SODDY-DAISY, TN 37379	Ē	
(X4) ID PREFIX TAG	I CAGM DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOU! D.RE	(X5) COMPLETION DATE
F 241	revealed the facility regarding the use of facility practice was	ge 1 dministrator, in the conference 28, 2012 at 11:10 a.m., did not have a written policy clothing protectors, but the for staff to ask the resident if ng protector prior to applying	F 241		.,	
F 322 SS=D	483.25(g)(2) NG TR RESTORE EATING Based on the compressident, the facility who is fed by a nasoreceives the approprion prevent aspiration vomiting, dehydration and nasal-pharynges possible, normal eating. This REQUIREMENT by:	ehensive assessment of a must ensure that a resident gastric or gastrostomy tube late treatment and services pneumonia, diarrhea, n, metabolic abnormalities, at ulcers and to restore if	F 322	1. Resident # 88's tube feed was discarded and a new bo feeding was started on Nove 29, 2012 by the Unit Manag resident was assessed by the Physician on November 30, Resident #88 did not experie any changes with Gastrointe status or negative outcome. 2. Residents receiving entera nutrition feeding have the poto be affected. A 100% audit conducted on November 29, of all residents receiving en	ttle of ember er. The 2012. ence stinal etential ewas 2012 enteral	
	record review, the lac	Cility tailed to monitor for		feeding and expiration dates	were	j
,	expiration dates for the feeding products for a seventy six residents. The findings included	neradministration of tube " one resident (#88), of reviewed.		-verified by the Director of Nursing and Assistant Direct Nursing. 3. All licensed Nurses were i serviced on Enteral Nutrition	n-	
	August 17, 2010, with Anemia, Atrial Fibrilla Disease, Congestive Gastro Esophageal R Mellitus, and End Sta	Heart Failure, Hypertension, Reflux Disease, Diabetes		expiration dates including verification prior to administration of tube feeding by the Director Nursing, Assistant Director onursing, Unit Manager, Super and / or Quality Assurance Ninitiated on November 29, 20 and completed on November	or of f rvisor, urses 012	

2012..

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/04/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO-0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445408 NAME OF PROVIDER OR SUPPLIER 11/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE SODDY-DAISY HEALTH CARE CENTER 701 SEQUOYAH ROAD SODDY-DAISY, TN 37379 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 4. An audit will be completed by F 322 Continued From page 2 F 322 the Licensed Nurse on each new dated October 4, 2012, revealed "Glucerna enteral feeding administration with (nutritional tube feeding product) 1.5... 60 cc/hr. via pump - may disconnect for personal care and expiration date verified by second showers. Flush tube with 250 cc H20 Q 6 hrs. via licensed nurse for three months ըստը," and / or until 100% compliant. An audit will be completed daily for Observation on November 29, 2012 in the one month, then three times resident's room at 12:05 p.m., revealed the weekly for two months and / or Glucerna tube feeding had been hung on until 100% compliant on 100% of November 28, 2012 at 11:55 p.m., and the residents receiving enteral feeding manufacturer's expiration date on the bottle by the Supervisor, Unit Manager, stated "use before Nov. 1, 2012". Director of Nursing, and / or Interview with Licensed Practical Nurse (LPN) #1 Assistant Director of Nursing for on November 29, 2012, at 12:10 p.m. in the verification of formula being resident's room, confirmed the tube feeding was administered and expiration date. expired and was not to be used after the All findings will be reviewed and expiration date of November 1, 2012. reported in the Quality Assurance 483.60(a),(b) PHARMACEUTICAL SVC -F 425! F 425 Performance Improvement SS=D ACCURATE PROCEDURES, RPH Committee meeting for three months and/or until 100% The facility must provide routine and emergency compliance is achieved. The drugs and biologicals to its residents, or obtain Quality Assurance Performance them under an agreement described in §483.75(h) of this part. The facility may permit Improvement Committee consists unlicensed personnel to administer drugs if State of the Administrator, Medical law permits, but only under the general Director, Director of Nursing, Staff supervision of a licensed nurse. Development Coordinator, Environmental Services, Dietary, A facility must provide pharmaceutical services Social Services Director, Business (including procedures that assure the accurate Office Manager, MDS acquiring, receiving, dispensing, and Coordinator, Rehabilitation administering of all drugs and biologicals) to meet Department, Medical Records, and the needs of each resident,

FORM CMS-2567(02-99) Previous Versions Obsolete

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy

Event ID: UZYR11

Facility ID: TN3315

Environmental Department

If continuation sheet Page 3 of 5

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/04/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB.NO., 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 8. WING 445408 11/30/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 SEQUOYAH ROAD SODDY-DAISY HEALTH CARE CENTER SODDY-DAISY, TN 37379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 425 | Continued From page 3

F 425

This REQUIREMENT is not met as evidenced Based on medical record review, review of facility guidelines, observation and interview the facility

failed to dispose of expired nutritional tube feeding products, making expired tube feedings available for administration for residents with Percutaneous Endoscopic Gastrostomy (PEG) tube feedings and failed to avoid the use of unapproved abbreviations on the Medication Administration Record (MAR) for one resident (#59) of seventy-six residents reviewed.

The findings included:

services in the facility.

Observation of the clean utility room on November 29, 2012, at 11:40 a.m., with Licensed Practical Nurse (LPN) #2, revealed eleven cans of Jevity (tube feeding product) 1.5 calorie with expiration dates of April 1, 2012 and one can of Jevity 1.5 calorie with an expiration date of November 1, 2012 and four one liter bottles of Glucerna (tube feeding product) 1.5 calorie with expiration dates of November 1, 2012.

Interview with LPN #2 on November 29, 2012 at 11:40 a.m., in the clean utility room, confirmed the tube feeding products were expired and available for resident use.

Review of the medical record for resident #59

la. The expired enteral feeding was immediately discarded from the clean utility room on November 29, 2012 by the Unit Manager. 1b. Resident # 59 received a corrected Medication

Administration record by the Director of Nursing and / or Assistant Director of Nursing on December 1, 2012. The Director of Nursing spoke to Pharmacy provider on November, 30, 2012 regarding the use of "units" for dosing of medication. 2a. An audit was completed on

November 29, 2012 of 100% clean utility rooms by the Director of

Nursing and Assistant Director of Nursing and no other expired enteral feeding was identified. 2b. Residents receiving medication with "units" for dosing have the potential to be affected, therefore Pharmacy completed an audit on all residents receiving insulin with changes to include "unit" for dosing on November 30, 2012 for monthly changeover of Medication Administration Records. The Consultant Pharmacist completed an audit of 100% of residents on December 3, 2012 for use of "u" in any medication dosage order. An audit was completed of 100% of residents Medication

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UZYR11

Facility ID: TN3315

If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
445408			B. WIN	1G		11/30/2012		
NAME OF PROVIDER OR SUPPLIER SODDY-DAISY HEALTH CARE CENTER				70	EET AODRESS, CITY, STATE, ZIP CODE 11 SEQUOYAH ROAD ODDY-DAISY, TN 37379			
(X4) ID PREFIX TAG	│ (≊ACH DEFICIENCY	TÊMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 425	the period November 2012. Review of facility gual Avoid, revealed "u" abbreviation. Interview with the Dance November 29, 2012 office, confirmed unand were to be writted to be abbreview with November 29, 2012 office, confirmed unand were to be writted.	"u" for units on the MAR for er 1, 2012 to November 30, lidelines titled Abbreviations to was an unapproved irector of Nursing (DON) on at 2:35 p.m., in the front lits were not to be abbreviated en out. In the pharmacy consultant on at 3:15 p.m., in the front lits were not to be abbreviated the MAR'S had not checked	F4	125	Administration record for of abbreviations to avoid a Director of Nursing, Unit Manager, and / or the Assisted Director of Nursing initiat December 3, 2012 and coron December 11, 2012. 3a. All licensed nurses we serviced on Enteral nutritic expiration dates including verification prior to admin by the Director of Nursing Assistant Director of Nursing Assistant Director of Nursing Manager, Supervisor, and Quality Assurance Nurse if on November 29, 2012 and completed on November 3. The Central Supply clerk we serviced by the Administration December 6, 2012 regarding procedure for stock rotation verification of expiration of and discarding of outdated supplies.	stant ed on inpleted re in- on and instration re, ing, Unit or initiated l 0, 2012. vas in- ator on ug in, ates,		
					3b. All licensed nurses we educated on the Abbreviati avoid guideline by the Dire Nursing, Assistant Directo Nursing, Unit Manager, Supervisor, and / or Qualit Assurance Nurse initiated November 29, 2012 and con November 30, 2012.	ons to ector of r of y on		
OBU 05:00	67/02-99) Previous Versions I	Obsolete Eurob ID-117VD-11					<u>:</u>	

Facility ID: TN3315

If continuation sheet Page 5 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY KETED
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NAME OF F	ROVIDER OR SUPPLIER			CTE	ACCULATION OF THE PROPERTY OF		<u>/30/2</u> 012
ا۔۲مومء	DAISY HEALTH CAR	E CENTER		70	LEET ADDRESS, CITY, STATE, ZIP CODE 01 SEQUOYAH ROAD ODDY-DAISY, TN 37379		
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					4a. An audit will be compleall enteral feeding upon deliweekly for 4 weeks, then m for two months and / or unticompliant by the Central Suclerk, Director of Nursing, Assistant Director of Nursing audit will be conducted threweekly of the clean utility for expiration dates on enterfeeding three times weekly month, then weekly for two months and / or until 100% compliant by the Central Suclerk, Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing Manager, and / or Supervise findings will be reviewed an reported in the Quality Assuperformance Improvement Committee meeting for three months and / or until 100% compliance is achieved. The Quality Assurance Performation of the Administrator, Medic Director, Director of Nursing Development Coordinator, Environmental Services, Di Social Services Director, But Social Services Director Services Director Services Director Services Director Services Directo	very onthly 1 100% 1 100% pply and / or ig An e times com al for one pply ig, Unit or. All id trance e ince insists al g, Staff etary,	
ORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	•	TITLE		(X8) DATE

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DEPART	MENT OF HEALT	HAND HUMAN SERVICES		, .): 12/04/2012 ((APPROVED
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		1		(X2) MULTIPLE CONSTRUCTION A. BUILDING), 0938-0391 SURVEY LETED
		445408	8. WII	≀G		1 447	30/2012
NAME OF PE	OVIDER OR SUPPLIER			STRF	ET ADORESS, CITY, STATE, ZIP CODE	11/-	3012012
SODDY-D	AISY HEALTH CAF	RE CENTER		701	SEQUOYAH ROAD DDY-DAISY, TN 37379		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
					Office Manager, MDS Coordinator, Rehabilitation Department, Medical Record Environmental Department. 4b. An audit will be complet five days a week in the more meeting of all new orders re- for appropriate use of units for one month, then three time weekly for two months and a until 100% compliant by the Director of Nursing, Assistan Director of Nursing, Unit Manager, Supervisor, and a Quality Assurance Nurse. A findings will be reviewed an reported in the Quality Assurance Committee meeting for three months and or until 100% compliance is achieved. The Quality Assurance Performa Improvement Committee co of the Administrator, Medica Director, Director of Nursin Development Coordinator, Environmental Services, Director, Bu Office Manager, MDS Coordinator, Rehabilitation	ed ing ceived daily nes or nt or ll d rance es nsists al g, Staff	
			; - -	:	Department, Medical Record Environmental Department	ds, and	
				•			i
MOURATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TULE		(X8) DATE

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